Healthcare Improvement Scotland

Key steps to setting up a front door frailty service

Form multidisciplinary frailty team*	Understand your system	Codesign the service	Develop and test pathway

• Develop shared vision and objectives.
• Create a project charter and driver diagram.
• Build relationships between clinicians and managers across emergency department, acute medicine, operational management and community partners.
• Hold regular core team meetings to share learning and build momentum.
• Develop frailty skills appropriate to role and responsibilities.
	• Identify key stakeholders within the hospital, community and pre-hospital interfaces.
	• Map current service against Healthcare Improvement Scotland's ageing and frailty standards (standard 10).
	• Map current journey of frail older adults through unscheduled care.
	• Identify baseline data.
	• Model demand for front door frailty service.
	• Identify and manage risks.
		Engage:
		• patients
		• families and carers
		• staff, and
		• use local patient experience teams where available.
			• Define frailty bed space in unscheduled care.
			• Agree remit of the frailty team, governance and reporting structures.
			• Develop the frailty pathway across unscheduled care, including processes for timely electronic identification and initiation of CGA.
			• Test Standard Operating Procedures (SOPs) including:
			  • Working as a team
			  • Prioritising workload
			  • How the pathway functions

Education for everyone working with older adults	Leadership to influence a whole system approach to frailty	Measuring progress and impact

***Multidisciplinary team may include** nursing, medicine, specialist frailty roles (nurses), specialist frailty roles (AHP), operational management, HSCP, pharmacy, social work, dietician, speech and language therapy, discharge coordinator, psychiatry, occupational therapy, physiotherapy, community frailty practitioners, adult social care.

Healthcare Improvement Scotland's frailty change package is for teams in health and social care partnerships (HSCPs), GP practices, and acute care settings interested in frailty improvement work. It is designed to support teams to improve the experience of access to person centered, coordinated health and social care, for people living with or at the risk of frailty. The change package consists of a number of high-level outcomes supported by activities that when tested and implemented, bring about improvement.